

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION POC #1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445154		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/10/2012	
NAME OF PROVIDER OR SUPPLIER QUALITY CARE HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 932 BADDOUR PARKWAY LEBANON, TN 37087			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS			F 000			
F 157 SS=D	<p>Complaint investigation #29933 and #30140 and 30410 were completed on August 21 -September 10, 2012. No deficiencies for #29933 and #30140 were cited under 42 CFR Part 483.13, Requirements for Long Term Care Facilities.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's</p>			F 157	<p>F157 483.10(b) (11) Notify of changes (Injury/Decline/Room)</p> <p>1) Upon being made aware by surveyor on 9/7/12 that the family was not immediately notified by LPN #1 or the DON timely, the Administrator conducted a one on one in-service with the DON and LPN#1 on timely notification as identified in Federal Regulations and Interpretive Guidelines. (Attachment #1)</p> <p>On 9/7/12 the Administrator conducted an in-service with all Department Heads and nursing management staff on the current policy to ensure resident safety and security as well as making timely notification of resident's responsible party and state per state regulation. (Attachment #2)</p>		9/20/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

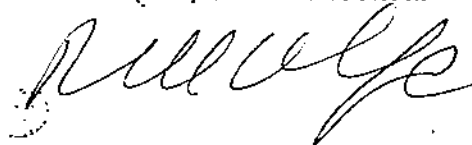
(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1</p> <p>legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility investigation, and interview, the facility failed to notify the resident's responsible party of an allegation of sexual abuse in a timely manner for one resident (#5) of five sampled residents.</p> <p>The findings included:</p> <p>Resident #5 was admitted to the facility on October 13, 2011, with diagnoses including Senile Dementia.</p> <p>Medical record review of a Minimum Data Set (MDS) dated July 23, 2012, revealed the resident was severely impaired with decision-making skills, wandered less than daily, and included, "...inattention...disorganized thinking...continuously present, does not fluctuate..."</p> <p>Medical record review of a Psychiatric Progress Note dated July 25, 2012, revealed, "...pleasant and cooperative...oriented to person, place, and situation..."</p> <p>Review of facility investigation (a statement signed by Licensed Practical Nurse - LPN) #1 dated August 22, 2012, at 10:10 p.m., revealed, "... (Resident #5) pointed at Certified Nursing Assistant - CNA #1...and said, (CNA #1) the one who touched me last night...CNA (#1) ask (asked) resident, 'What's wrong...and (resident) stated, 'don't talk to me you tried to rape me last night...'"</p>	F 157	<p>On 9/10/12 the Administrator reviewed and revised the current Abuse Policy to clarify the investigation and reporting section. The Administrator also revised the Abuse Section of the orientation process to include the reporting and prevention of Abuse. (Attachment #3)</p> <p>2) On 9/14/12 the Administrator review the revised Abuse Policy with all management staff and DON to ensure if other residents have a reported allegation of sexual abuse the responsible party will be notified in a timely manner. (Attachment #4)</p> <p>Beginning on 9/14/12-9/18/12 the DON reviewed all incident reports for the past 3 months for timely reporting to the resident's responsible party. Two hundred and eighty six incident reports were reviewed with no variances.</p> <p>On 9/18/12, 9/19/12 & 9/20/12 in-services were conducted by the DON & ADON with all licensed staff (RNs & LPNs) and CNAs on the Abuse policy. Any RN, LPN or CNA not attending the in-service will not be allowed to return to work until they have attended this in-service. (Attachment #5)</p>		



Administrator

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F 157	Continued From page 2 Medical record review of nurse's notes dated August 22, 2012, through August 23, 2012, at 5:30 a.m., revealed no documentation the resident's responsible party was notified of the resident's allegation of sexual abuse. Review of facility investigation (an unsigned statement) dated August 23, 2012, at 8:30 a.m., revealed, "Spoke with (Resident's) son and informed him that in the PM (p.m.) of 8/22/12... (resident)...said, '(Certified Nursing Assistant - CNA #1)...tried to rape me last night...' Review of a Resident Abuse Investigation Form dated August 24, 2012, revealed, "... (Resident #5)... Date Incident Occurred: 8/21/12... Date Incident Reported: 8/22/12... Time: 9:00 (p.m.)... resident...pointing @ (at) (Certified Nursing Assistant - CNA #1)...stated 'Don't talk to me. You raped me last 'noc' (night)...'. Continued review revealed, "...reported to: Representative... (responsible party) Date: 8/23/12... By Whom: (Director of Nursing)..." Interview with LPN #2 on September 6, 2012, at 6:20 p.m., in a conference room, revealed the facility was aware of the allegation of sexual abuse on August 22, 2012, at 9:00 p.m., and LPN #2 completed the investigation of the resident's allegation. Continued interview confirmed the facility failed to notify the resident's responsible party of the allegation in a timely manner. C/O: #30410	F 157	On 10/5/12 a quarterly in-services will be conducted by the DON, ADON, or Staff Educator on Abuse Policy. This will continue for 12 months. 3) Effective 9/10/12 the DON and Administrator will monitor the timely reporting of the resident's responsible party. This will continue indefinitely. 4) Beginning 9/18/12, the DON will report quarterly to the QI Committee concerning the monitoring outcomes for timely notification of resident's responsible party. This will continue until substantial compliance is achieved or the QAPI Committee reduces monitoring. The next QI Committee meeting is scheduled for 9/18/12. The Administrator will report to the governing Body concerning these monitoring outcomes on a quarterly basis beginning 9/18/12. (Attachment #6)		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		9/20/2012	

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F 225	<p>Continued From page 3</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 225	<p>F 225 483.13(c)(1)(1)(ii)(iii), (c)(2) – (4) Investigate/Report/allegations/Individuals</p> <p>1) On 9/10/12 the DON completed the facility's unsigned statement of August 22, 11:00 PM investigation report with last names on witness statement, signatures and relationship to resident.</p> <p>On 9/10/12 the DON conducted a one on one in-service with LPN # 2 on completion of investigative documents – full names on documents, dates on documents, unsigned documents, completing all sections of investigative forms, and including policy investigation outcomes in the facility management final document. (Attachment #7)</p> <p>2) On 9/13/12 the DON and ADON reviewed all investigations for July, Aug, September for full names, signatures, completion of all sections on the abuse investigation form.</p> <p>On 9/14/12 the DON & ADON reviewed and revised the skin assessment form to improve on capturing assessment data , signatures, and date. (Attachment #8)</p>		

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F 225	<p>Continued From page 4</p> <p>by:</p> <p>Based on medical record review, review of facility investigation, review of a police department report, observation, and interview, the facility failed to thoroughly investigate an allegation of sexual abuse for one resident (#5) of five sampled residents.</p> <p>The findings included:</p> <p>Resident #5 was admitted to the facility on October 13, 2011, with diagnoses including Senile Dementia.</p> <p>Medical record review of a Minimum Data Set (MDS) dated July 23, 2012, revealed the resident was severely impaired with decision-making skills, wandered less than daily, and included, "...inattention...disorganized thinking...continously present, does not fluctuate..."</p> <p>Medical record review of a Psychiatric Progress Note dated July 25, 2012, revealed, "...pleasant and cooperative...oriented to person, place, and situation..."</p> <p>Review of facility investigation provided by Licensed Practical Nurse (LPN) #2 on September 6, 2012, revealed an undated, untimed, and unsigned Skin Assessment and included, "...Red on left side of neck from chin to shoulder...blood vessels on both right and left top thigh..."</p> <p>Continued review revealed, "1. Discoloration bluish-purple quarter size 1 inch long (old)...(outer sides of both knees) 2. Red circle quarter size (old) (just below left elbow) 3. Discoloration dark purple dime size (old) (left elbow) 4. Discoloration bluish-purple dime size (old) (left hand)...6.</p>	F 225	<p>On 9/18/12, 9/19/12 and 9/20/12 the DON & ADON conducted in-services for all licensed nursing staff (RNs & LPNs) concerning the revised skin assessment form including capturing signatures, date & time. Any nursing staff not attending will not be allowed to work until they have attended the above in-service.</p> <p>3) On 9/12/12 the Administrator began monitoring each investigative file of Abuse Investigations for signatures, full names on all documents, completion of all sections of the investigative forms including any police investigative information in the final outcome statement. This monitoring will continue indefinitely by the Administrator.</p> <p>4) On 9/18/12, the Administrator will begin reporting quarterly to the QI Committee concerning the monitoring outcomes for completion of investigative forms relative to signatures, full names, completions of all sections. This will continue until substantial compliance is achieved or the QI Committee reduces monitoring. The next QI Committee meeting is scheduled for 9/18/12. The Administrator will report to the governing Body concerning these monitoring outcomes on a quarterly basis beginning 9/18/12. (Attachment #6)</p>		

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Administrator

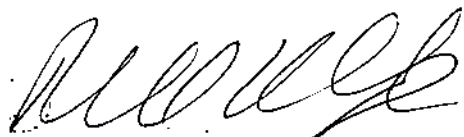
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F 225	<p>Continued From page 5</p> <p>discoloration dark purple quarter size (old) (back left knee) 7. Discoloration (old) dime sized (right hand)..."</p> <p>Review of facility investigation (an unsigned statement) dated August 22, 2012, at 10:00 p.m., revealed, "...at approximately 6:15 (p.m.) I witnessed (resident)...visiting with...son...behavior calm...At approximately 9:45 (p.m.) I spoke with (resident)...refused (something to eat)..."</p> <p>Review of facility investigation (a statement signed by Licensed Practical Nurse - LPN) #1 dated August 22, 2012, at 10:10 p.m., revealed, "... (Resident #5) pointed at Certified Nursing Assistant - CNA #1)...and said, (CNA #1) the one who touched me last night...CNA (#1) ask resident, 'What's wrong...and (resident) stated, 'don't talk to me you tried to rape me last night...'"</p> <p>Review of facility investigation (an unsigned "Interview with Resident") dated August 23, 2012, at 8:00 a.m., revealed, "I understand that you reported someone touched you inappropriately...know who it was 'no'..."</p> <p>Review of facility investigation (an unsigned statement) dated August 23, 2012, at 8:30 a.m., revealed, "Spoke with (Resident's) son and informed him that in the PM (p.m.) of 8/22/12... (resident)...said, 'Certified Nursing Assistant - CNA #1)...tried to rape me last night...told him we would do an internal investigation and would also be calling the police..."</p> <p>Review of a Resident Abuse Investigation Form dated August 24, 2012, revealed, "... (Resident #5)...Date Incident Occurred: 8/21/12...Date</p>	F 225			



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F 225	<p>Continued From page 6</p> <p>Incident Reported: 8/22/12...resident...pointing @ (at) (Certified Nursing Assistant - CNA #1)...stated 'Don't talk to me. You raped me last 'noc' (night)...'. Continued review revealed, "...Did the findings indicate that abuse occurred? No (if NO, please explain)...". The "explanation" section of the form was blank.</p> <p>Review of a facility investigation report dated August 28, 2012, revealed, "...Officer (police) decided that a full investigation and rape kit was unnecessary..."</p> <p>Review of facility investigation revealed no documentation by a police officer regarding the investigation.</p> <p>Observation and interview with LPN #3 on September 6, 2012, at 6:55 p.m., in a staff development room, revealed a security camera tape dated August 22, 2012, from 2:00 p.m. through 10:00 p.m. (the night after the abuse was alleged to have occurred). Continued interview revealed LPN #3 had not reviewed the security tape after CNA #1's shift ended. Continued interview revealed LPN #3 had reviewed the security tapes for the week including August 22, 2012 but only during the times CNA #1 was on duty.</p> <p>Observation and interview with the resident on September 6, 2012, at 6:50 p.m., in the resident's room, revealed no visible bruises and the resident was unable to identify (resident's) last name and disoriented to time, place, and situation.</p> <p>Interview with LPN #2 on September 6, 2012, at 6:20 p.m., in a conference room, revealed LPN</p>	F 225			

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F 225	Continued From page 7 #2 interviewed the resident on August 23, 2012. Continued interview revealed LPN #2 completed the facility's investigation regarding the resident's allegation and witness statements did not include last names, signatures, and/or the relationship of the witnesses to the resident. Continued interview confirmed the facility failed to thoroughly investigate Resident #5's allegation of sexual abuse on August 22, 2012.	F 225			
F 226 SS=D	C/O: #30410 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, review of facility investigation, review of a police department report, and interview, the facility failed to implement the abuse policy for one resident (#5) of five sampled residents. The findings included: Review of facility policy titled "(facility) Abuse and Neglect Prohibition Policy dated August 10, 2012, revealed, "...All alleged violations involving mistreatment, neglect, abuse...will be reported immediately to the administrator of the facility and to other officials in accordance with state law through established procedures...Sexual abuse	F 226	F 226 483.13(c) Develop/Implement abuse/Neglect, etc Policies 1) On 9/7/12 the Administrator conducted an in-service with all Department management staff on reporting of abuse, investigating abuse, and completing investigative forms. (Attachment #2) On 9/10/12 the Administrator reviewed and revised the current Abuse Policy to clarify the reporting and investigation section. The Administrator also revised the Abuse Section of the orientation process to include the reporting and prevention of Abuse. (Attachment #3) On 9/12/12 the DON identified the nurse who conducted the Skin Assessment that was undated, untimed, and unsigned and obtained all information including the source of the findings for that skin assessment.	9/20/2012	

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F 226	<p>Continued From page 8</p> <p>includes, but not limited to sexual harassment, sexual coercion, or sexual assault...Injury of unknown source is defined as an injury that meets both of the following conditions: a. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and...the number of injuries observed at one particular point in time...The facility will train employees...How staff should report their knowledge related to allegations...The Administrator or designee will report all allegations and substantiated occurrences of mistreatment, neglect, abuse...to the state agency and law enforcement officials as designated by state law..."</p> <p>Resident #5 was admitted to the facility on October 13, 2011, with diagnoses including Senile Dementia.</p> <p>Medical record review of a Minimum Data Set (MDS) dated July 23, 2012, revealed the resident was severely impaired with decision-making skills, wandered less than daily, and included, "...inattention...disorganized thinking...continuously present, does not fluctuate..."</p> <p>Medical record review of a Psychiatric Progress Note dated July 25, 2012, revealed, "...pleasant and cooperative...oriented to person, place, and situation..."</p> <p>Review of facility investigation (a statement signed by Licensed Practical Nurse - LPN) #1 dated August 22, 2012, at 10:10 p.m., revealed, "... (Resident #5) pointed at Certified Nursing Assistant - CNA #1)...and said, (CNA #1) the one who touched me last night...CNA (#1) ask</p>	F 226	<p>2) On 9/14/12, 9/15/12, & 9/17/12 the DON & ADON conducted surveys of other residents for accurately completed skin assessments and any positive findings not reported per incident reporting process.</p> <p>On 9/14/12 the DON & ADON reviewed and revised the skin assessment form to improve on capturing assessment data, signatures, and date. (Attachment #8)</p> <p>On 9/14/12 the Administrator reviewed the other allegation of abuse for accuracy and completeness of the "Resident Abuse Investigative Form". (Attachment #9)</p> <p>On 9/18/12, 9/19/12 and 9/20/12 the DON & ADON conducted in-services for all licensed nursing staff (RNs & LPNs) concerning the revised skin assessment form including capturing signatures, date & time. Any nursing staff not attending will not be allowed to work until they have attended the above in-service. (Attachment #5)</p>		

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NAME OF PROVIDER OR SUPPLIER QUALITY CARE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 932 BADDOUR PARKWAY LEBANON, TN 37087		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	<p>Continued From page 9</p> <p>(asked) resident, 'What's wrong...and (resident) stated, 'don't talk to me you tried to rape me last night'...I went to charge nurse and ask (asked)...what to do with information and (charge nurse) stated...was unsure, but to notify supervisor probably..."</p> <p>Review of facility investigation provided by Licensed Practical Nurse (LPN) #2 on September 6, 2012, revealed an undated, untimed, and unsigned Skin Assessment and included, "...Red on left side of neck from chin to shoulder...blood vessels on both right and left top thigh..." Continued review revealed, "1. Discoloration bluish-purple quarter size 1 inch long (old)...(outer sides of both knees) 2. Red circle quarter size (old) (just below left elbow) 3. Discoloration dark purple dime size (old) (left elbow) 4. Discoloration bluish-purple dime size (old) (left hand)...6. discoloration dark purple quarter size (old) (back left knee) 7. Discoloration (old) dime sized (right hand)..." Continued review revealed no documentation regarding a source of the injuries.</p> <p>Review of facility investigation (an unsigned statement) dated August 23, 2012, at 8:30 a.m., revealed, "Spoke with (Resident's) son and informed him (of allegation of attempted rape)..."</p> <p>Review of a Resident Abuse Investigation Form dated August 24, 2012, revealed, "... (Resident #5)...Date Incident Occurred: 8/21/12...Date Incident Reported: 8/22/12 Time: 9 (p.m.) ...resident...pointing @ (at) (Certified Nursing Assistant - CNA #1)...stated 'Don't talk to me. You raped me last 'noc' (night)..." Continued review revealed, "...Did the findings indicate that abuse occurred? No (if NO, please explain)..." The</p>	F 226	<p>3) On 9/18/12 the DON, ADON, and Unit Managers began monitoring the completion of the skin assessment for accuracy, signatures, and full names on all assessments. This monitoring will continue for at least 6 months and then the QI committee will determine frequency of monitoring at the end of 6 months. (Attachment #10)</p> <p>On 9/12/12 the Administrator began to monitor each investigative file of Abuse Investigations for signatures, full names on all documents, completion of all sections of the investigative forms. This monitoring will continue indefinitely by the Administrator.</p> <p>4) Beginning 9/18/12, the DON will report quarterly to the QI Committee concerning the monitoring outcomes for completion of Skin Assessment Form and completion of incident report for any positive findings. This will continue until substantial compliance is achieved or the QAPI Committee reduces monitoring. The next QI Committee meeting is scheduled for 9/18/12. The Administrator will report to the governing Body concerning these monitoring outcomes on a quarterly basis beginning 9/18/12. (Attachment #6)</p>		

[Handwritten Signature]

Admin 6/2/12

9/20/2012

SEP 24 2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2012
FORM APPROVED
OMB NO. 0938-0391

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F 226	<p>Continued From page 10</p> <p>"explanation" section of the form was blank. Continued review revealed, "...Results of findings...reported to: Representative (Sponsor) Date: 8/23/12...Law Enforcement Agencies Date: 8/23/12...Administrator Date: 8/22/12..."</p> <p>Review of a local police department Incident Details Report dated August 23, 2012, revealed a call was received at 9:37:02 (a.m.) and included, "...Personal Details: ...Caller...(Director of Nursing - DON)...caller is a MGR (manager) and advised one of the patients is stating someone attempted 10/55 B (rape)."</p> <p>Telephone interview with the Administrator on September 10, 2012, at 12:35 p.m., confirmed the facility failed to implement the abuse policy for Resident #5 on August 22, 2012.</p> <p>C/O: #30410</p>	F 226			

[Handwritten Signature]

Administrator

9/20/2012

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